TESTIMONY OF
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Before the Public Health Committee
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AAC, SB 248, An Act Concerning Adverse Events
At Hospitals and Outpatient Surgical Facilities

Good Afternoon. My name is Dr. Thomas Balcezak and I am the vice president of performance management and associate chief of staff at Yale-New Haven Hospital. I appreciate the opportunity to testify for Yale-New Haven Hospital in opposition to **Senate Bill 248, An Act Concerning Adverse Events at Hospitals and Outpatient Surgical Facilities**.

In my role at Yale-New Haven Hospital, I am responsible for oversight of all clinical quality, patient safety and operations improvement efforts for the Hospital.

I believe the proposed Senate Bill is well-intentioned. However, it would not improve the State's current adverse event reporting system, and would likely work as a disincentive to reporting events and improving patient safety. Confidentiality in adverse event reporting is essential to the process. The primary purpose of reporting is to learn from experience, and to make improvements based learning, not to impose punitive sanctions and penalties. Adverse event reporting is a critical first step toward taking corrective action. It is proven that confidential systems encourage, rather than discourage, reporting of adverse events. It is also proven than punitive systems that use public blame and shame reduce reporting rates, thus reducing opportunities for improvement.

In medical care, as in the aviation industry, it is established that improvements in safety come from creating a non-punitive environment, learning from errors, and moving away from looking at errors as individual failures to realizing that they are caused by system failures.

Confidential, non-punitive reporting systems increase reporting, while punitive systems discourage such transparency. Hospitals currently report adverse events and the annual DPH public report of aggregated data has helped hospitals identify problems and has led to improvements in the two most commonly reported events: falls with injury and pressure ulcers.

Removing confidentiality from this reporting process, and imposing fines will have a chilling effect on adverse event reporting. We want to encourage reporting, and the national trend in healthcare is to create a culture of safety where reporting is encouraged, not punished. Our goal is to increase reporting in order to learn from our experiences and, as experience with the aviation industry has demonstrated, individual public

disclosure of events does not drive improvements in safety. Improvements in safety are driven by careful evaluation of events and systems improvements based on findings.

To conclude, at Yale-New Haven Hospital, our highly skilled patient care teams provide safe, high quality patient care to thousands of Connecticut residents. When errors occur, I can assure you that we promptly and thoroughly investigate them to identify the cause, learn from our findings, and most importantly, prevent recurrence.

I respectfully urge your opposition to SB 248 which would likely erode the safety culture we have worked diligently to foster as a means of improving patient care. Thank you for your consideration of our position.